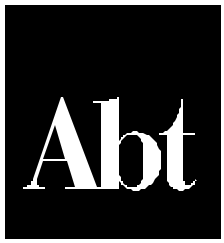

Abt Associates Inc.

Costs and Benefits of HCAHPS

Executive Summary

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Cambridge, MA
Lexington, MA
Hadley, MA
Bethesda, MD
Chicago, IL

Prepared for
Elizabeth Goldstein
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Abt Associates Inc.
55 Wheeler Street
Cambridge, MA 02138

Prepared by
Harmon Jordan, PhD
Alan White, PhD
Catherine Joseph
Darcy Carr

Background

As part of the Hospital Quality Initiative, the Centers for Medicare and Medicaid Services (CMS) developed the Hospital CAHPS (HCAHPS) survey. HCAHPS was designed as the first national survey to collect uniform patient feedback ("patient perspectives") on hospital care, with a standardized survey and data collection methodology. Participation will be voluntary, and results will be publicly reported on the CMS Hospital Compare website beginning in 2006. Public reporting of HCAHPS results is intended to support consumer choice, encourage provider accountability, and create patient perspective-driven hospital performance incentives.

HCAHPS currently contains 27 items covering seven domains of patient perspectives on care, an overall rating of the quality of hospital care, and whether the patient would recommend the hospital to others. To develop HCAHPS, CMS partnered with the Agency for Healthcare Research and Quality (AHRQ) in a comprehensive process to ensure that the survey would produce credible, useful information. In May 2005, the National Quality Forum (NQF) endorsed the 27-item HCAHPS survey. Responding to an NQF recommendation for further analysis of the costs and benefits of HCAHPS, CMS contracted with Abt Associates Inc. to conduct a short-turnaround focused study to examine potential benefits and to compare costs of the 27-item version of HCAHPS to costs of a shorter version.

Weighing the Costs and Benefits of HCAHPS

Decisions about the most appropriate version of HCAHPS depend on a comparison of the marginal benefits and costs associated with the longer survey. There is insufficient information to know either that HCAHPS will lead to better choices and contribute to improved hospital quality of care or that it will not lead to improvements in these outcomes. The marginal costs associated with a longer version of HCAHPS are likely to be relatively small, and if there is a reasonable basis for believing that the 27-item version of HCAHPS offers better information to consumers than a shorter alternative, there are good reasons for implementing the current 27-item version.

Potential Benefits and Limitations of HCAHPS

Public reporting of hospital clinical performance has an impact on quality improvement. There are multiple reports of hospitals using these data for improvement, and some well-designed studies have found at least some impact on clinical performance. Less research has been conducted on the impact of publicly reporting patient perspectives data.

Consumers want patient perspectives on care ratings, but researchers are in the early stages of understanding whether and how consumers will use these ratings. Consumer focus groups suggest that consumers want to know what fellow patients think of the care they have received. The extent to which they use such information to choose hospitals is unknown. However, some of the stakeholders that we interviewed felt that consumers might more easily relate to ratings of patient perspectives on hospital care than to currently published ratings that focus on clinical procedures and outcomes.

Most stakeholders whom we interviewed are in favor of some form of HCAHPS. In addition to the NQF endorsement, several of the stakeholders with whom we spoke -- including the major hospital patient satisfaction survey vendors -- emphasized that they are in favor of standardized measures, and mentioned specific potential benefits. Benefits to consumers centered on the support of consumer choice, and benefits to hospitals focused on quality improvement and uniform comparisons. With regard to overall limitations of HCAHPS, concerns were most often voiced by the major survey vendors and included such concerns as disrupting analysis of ongoing longitudinal vendor surveys and concern about impact on hospital staff incentive structures.

A difference in visions has led to differing views about how long the HCAHPS instrument should be and about what items it should contain. CMS and AHRQ used a systematic and comprehensive process to assess the length of the survey instrument. There is an ongoing debate about the 27-item length, which is due in part to the fact that some stakeholders (primarily some survey vendors) envision a different set of objectives than those specified by CMS. Some of the analysis supporting a shorter instrument assumes that the item "willingness of patients to recommend a hospital" is the only outcome of interest, in contrast to the broader objectives for HCAHPS. One of the major hospital satisfaction survey vendors and four of the other organizations felt that HCAHPS should remain a 27-item survey; consumer research supports this approach. In contrast, three of the four major survey vendors and one of the other organizations felt that HCAHPS should include no more than 6-10 items.

Potential Costs of HCAHPS

The costs of collecting HCAHPS will vary across hospitals. This is due to whether a hospital currently uses patient surveys, the methods currently used to collect patient survey data, the number of patients surveyed, and whether it is possible to incorporate HCAHPS into existing surveys. The cost estimates provided in the study are for data collection and transmission to CMS only and do not include administrative, information technology, or other costs that hospitals may incur as a result of HCAHPS, costs that may be considerable and may vary, but that were beyond the scope of this study.

The average costs of the 27-item HCAHPS collected as a separate survey are estimated to be between $3,300 to $4,575 per hospital. Costs of a shorter (7-item) version of HCAHPS administered as a separate survey are estimated to be about $2,361 per hospital. These estimates assume that most hospitals would collect HCAHPS by mail (as many currently do for patient surveys), and some would collect it by phone or active interactive voice response (IVR).

The costs for combining HCAHPS with existing surveys would be considerably less. It would cost $978 per hospital to incorporate the 27-item version of HCAHPS into existing surveys. The estimated marginal cost of incorporating a shorter version of HCAHPS into existing surveys is between $0 and $609 per hospital. This lower bound estimate is based on information from several major vendors that they could incorporate a shorter version of HCAHPS at no additional cost to hospitals.

The nationwide cost of HCAHPS is estimated to be between $4.1 and $19.1 million per year. The range depends on the proportion of hospitals that incorporate the 27-item version of HCAHPS into existing surveys. The annual costs of a shorter version of HCAHPS are estimated to between $2.5 and $4.7 million if 75 percent of hospitals combine the shorter version with existing surveys, and between $1.0 and $3.6 million if 90 percent of hospitals combine it with existing surveys. In the context of overall hospital expenditures, HCAHPS represents a small expenditure, but concerns about the financial impact of HCAHPS may be valid, given the negative Medicare margins currently being experienced by hospitals.

There appear to be significant savings associated with combining HCAHPS with existing surveys, and hospitals may have a financial incentive to combine HCAHPS with their existing surveys. Since some vendors have indicated that they are able to integrate HCAHPS with their patient satisfaction surveys, this may place competitive pressure on other companies to also offer integrated surveys to their clients. Potentially offsetting the cost efficiencies associated with combining HCAHPS with existing surveys are several statistical issues that raise concerns about whether it is appropriate to combine HCAHPS with existing surveys (e.g., the impact of a longer survey on response rates, the impact of different response options used in HCAHPS and patient satisfaction surveys, and the impact of adding HCAHPS to the flow of patient surveys).

Cost considerations are not a sufficient reason for switching from the current version of HCAHPS to a shorter version. There are potential cost savings associated with reducing the length of HCAHPS, but the upper bound estimate of these potential savings is $19.1 million per year (this assumes that the shorter version of HCAHPS would be incorporated at zero cost). The actual savings are likely to be less, given that many hospitals are likely to incorporate HCAHPS into their existing surveys and some hospitals would likely incur data collection costs even with a shorter version.